

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	46	TOTALS	46	16,790	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	13	478	835	1,326	8
9	SNF/PED					9
10	ICF	7,454	5,408	151	13,013	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,467	5,886	986	14,339	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.40%

D. How many bed-hold days during this year were paid by Public Aid? 4 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 12/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/1/93 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 46 and days of care provided 705

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	138,147	4,589	2,534	145,270		145,270	(4,156)	141,114		1
2	Food Purchase		72,494		72,494	(606)	71,888	(413)	71,475		2
3	Housekeeping	95,993	15,625		111,618		111,618	(2,085)	109,533		3
4	Laundry	25,007	5,945		30,952		30,952	(759)	30,193		4
5	Heat and Other Utilities			30,986	30,986		30,986	314	31,300		5
6	Maintenance	38,885	13,259	13,744	65,888		65,888	(3,932)	61,956		6
7	Other (specify):*							25	25		7
8	TOTAL General Services	298,032	111,912	47,264	457,208	(606)	456,602	(11,006)	445,596		8
	B. Health Care and Programs										
9	Medical Director			7,375	7,375		7,375		7,375		9
10	Nursing and Medical Records	679,146	37,617	11,824	728,587		728,587	(13,073)	715,514		10
10a	Therapy			280	280		280		280		10a
11	Activities		8,610	1,104	9,714		9,714		9,714		11
12	Social Services	3,390		1,079	4,469		4,469		4,469		12
13	Nurse Aide Training										13
14	Program Transportation			333	333		333	(333)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	682,536	46,227	21,995	750,758		750,758	(13,406)	737,352		16
	C. General Administration										
17	Administrative	89,384			89,384		89,384	19,476	108,860		17
18	Directors Fees										18
19	Professional Services			48,431	48,431	(7,935)	40,496	(13,228)	27,268		19
20	Dues, Fees, Subscriptions & Promotions			12,290	12,290		12,290	(8,150)	4,140		20
21	Clerical & General Office Expenses	26,485	12,390	20,176	59,051		59,051	5,803	64,854		21
22	Employee Benefits & Payroll Taxes			151,885	151,885	606	152,491		152,491		22
23	Inservice Training & Education										23
24	Travel and Seminar			739	739		739	84	823		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,171	39,171		39,171	1,033	40,204		26
27	Other (specify):*							4,272	4,272		27
28	TOTAL General Administration	115,869	12,390	272,692	400,951	(7,329)	393,622	9,290	402,912		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,096,437	170,529	341,951	1,608,917	(7,935)	1,600,982	(15,122)	1,585,860		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

#0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			13,666	13,666		13,666	36,200	49,866			30
31	Amortization of Pre-Op. & Org.							688	688			31
32	Interest			662	662		662	89,067	89,729			32
33	Real Estate Taxes			95,572	95,572	7,935	103,507	913	104,420			33
34	Rent-Facility & Grounds			170,125	170,125		170,125	(170,125)				34
35	Rent-Equipment & Vehicles			7,447	7,447		7,447	2,670	10,117			35
36	Other (specify):*											36
37	TOTAL Ownership			287,472	287,472	7,935	295,407	(40,587)	254,820			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,078	22,987	43,065		43,065		43,065			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,185	25,185		25,185		25,185			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		20,078	48,172	68,250		68,250		68,250			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,096,437	190,607	677,595	1,964,639		1,964,639	(55,709)	1,908,930			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	861	30		9
10	Interest and Other Investment Income	(662)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(295)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(85)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,500)	21		24
25	Fund Raising, Advertising and Promotional	(6,983)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,109)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,773)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,936)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,936)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (55,709)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

OHF USE ONLY					
48		49		50	
				51	
				52	

SEE ACCOUNTANTS' COMPILATION REPORT

HW 0039255
 Report Period Beginning: 01/01/02
 Ending: 12/31/02

NON-ALLOWABLE EXPENSES	Amount	Reference
1 COPE Dues	(800)	20 1
2 Franchise Tax	(495)	20 2
3 Late Fees	(240)	21 3
4 Discounts	(118)	2 4
5 Capitalized Repairs & Maintenance	(3,164)	6 5
6 Bank Charges	(370)	21 6
7 Rent - Apartment	(2,125)	24 7
8 Trust Fees (Building Partnership)	(200)	21 8
9 Income Taxes (Building Partnership)	(616)	21 9
10 Out of Period Legal Fees	(81)	19 10
11 Prior Period Adjustment - Legal Fees	(4,925)	19 11
12 Prior Period Adjustment - Patient Transportation	(233)	14 12
13 Prior Period Adjust-Vacation Pay-Administrator	(1,288)	17 13
14 Prior Period Adjust-Vacation Pay-CNAs	(7,256)	10 14
15 Prior Period Adjust-Vacation Pay-Dietary	(4,150)	1 15
16 Prior Period Adjust-Vacation Pay-Hkps	(2,885)	3 16
17 Prior Period Adjust-Vacation Pay-Laundry	(759)	4 17
18 Prior Period Adjust-Vacation Pay-Maint	(2,720)	6 18
19 Prior Period Adjust-Vacation Pay-Nursing	(5,717)	10 19
20 Prior Period Adjust-Vacation Pay-Office	(2,571)	21 20
21		21
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29		29
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
40		40
41		41
42		42
43		43
44		44
45		45
46		46
47		47
48		48
49		49
50		50
51		51
52		52
53		53
54		54
55		55
56		56
57		57
58		58
59		59
60		60
61		61
62		62
63		63
64		64
65		65
66		66
67		67
68		68
69		69
70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90		90
91		91
92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(39,109)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK RIDGE CARE CENTER# 0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(4,156)											(4,156)	1
2	Food Purchase	(413)											(413)	2
3	Housekeeping	(2,085)											(2,085)	3
4	Laundry	(759)											(759)	4
5	Heat and Other Utilities			314									314	5
6	Maintenance	(4,894)		962									(3,932)	6
7	Other (specify):*			25									25	7
8	TOTAL General Services	(12,307)		1,301									(11,006)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(13,073)											(13,073)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation	(333)											(333)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(13,406)											(13,406)	16
	C. General Administration													
17	Administrative	(1,288)			20,764								19,476	17
18	Directors Fees													18
19	Professional Services	(5,016)		(8,212)									(13,228)	19
20	Fees, Subscriptions & Promotions	(8,363)		213									(8,150)	20
21	Clerical & General Office Expenses	(9,467)	816	12,509	1,945								5,803	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			84									84	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,033									1,033	26
27	Other (specify):*			2,150		2,122							4,272	27
28	TOTAL General Administration	(24,134)	816	7,777	22,709	2,122							9,290	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,847)	816	9,078	22,709	2,122							(15,122)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	861	33,923	1,416									36,200	30
31	Amortization of Pre-Op. & Org.		688										688	31
32	Interest	(662)	88,483	1,246									89,067	32
33	Real Estate Taxes			913									913	33
34	Rent-Facility & Grounds	(2,125)	(168,000)										(170,125)	34
35	Rent-Equipment & Vehicles			2,670									2,670	35
36	Other (specify):*													36
37	TOTAL Ownership	(1,926)	(44,906)	6,245									(40,587)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,773)	(44,090)	15,323	22,709	2,122							(55,709)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Leo Mauer	25	None		665 Busse Hwy.	Park Ridge	Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 168,000	665 Busse Highway Ltd. Partnership	100.00%	\$	\$ (168,000)	1
2	V	32 Interest Income	384	665 Busse Highway Ltd. Partnership	100.00%		(384)	2
3	V	31 Amortization		665 Busse Highway Ltd. Partnership	100.00%	688	688	3
4	V	30 Depreciation		665 Busse Highway Ltd. Partnership	100.00%	33,923	33,923	4
5	V	32 Interest		665 Busse Highway Ltd. Partnership	100.00%	88,867	88,867	5
6	V	21 Trust Fees		665 Busse Highway Ltd. Partnership	100.00%	200	200	6
7	V	21 State Income Taxes		665 Busse Highway Ltd. Partnership	100.00%	616	616	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 168,384			\$ 124,294	\$ * (44,090)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 314	\$	314	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	962		962	16
17	V	7 EMP.BEN. - GEN. SERVICES		DYNAMIC HEALTH CARE CONS.	100.00%	25		25	17
18	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	638		638	18
19	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	213		213	19
20	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	12,509		12,509	20
21	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	84		84	21
22	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	1,033		1,033	22
23	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	2,150		2,150	23
24	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	1,416		1,416	24
25	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	1,246		1,246	25
26	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	913		913	26
27	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	2,670		2,670	27
28	V								28
29	V	19 BOOKKEEPING FEES	8,850					(8,850)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 8,850			\$ 24,173	\$ *	15,323	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$	\$	15
16	V	10 NURSING CMP - SUE G.						16
17	V	17 ADMIN. CMP. - M. MAUER				12,073	12,073	17
18	V	17 ADMIN. CMP. - M. AARON						18
19	V	17 ADMIN. CMP. - F. AARON						19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17 ADMIN. CMP. - S. KOPLIN						21
22	V	17 ADMIN. CMP. - D. MAGAFAS				4,022	4,022	22
23	V	17 ADMIN. CMP. - E. CASSON						23
24	V	17 ADMIN. CMP. - S. BOGEN						24
25	V	17 ADMIN. CMP. - S. LEVY				4,669	4,669	25
26	V	17 ADMIN. CMP. - HOWARD ALTER						26
27	V	17 ADMIN. CMP. - NON-OWNER						27
28	V	21 CLERICAL CMP. - S. AARON				1,945	1,945	28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 22,709	\$ * 22,709	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$	\$
16	V	15 EMP. BEN.- SUE G.					
17	V	27 EMP. BEN.- M. MAUER				525	525
18	V	27 EMP. BEN.- M. AARON					
19	V	27 EMP. BEN.- F. AARON					
20	V	27 EMP. BEN.- S. GOLDSTEIN					
21	V	27 EMP. BEN.- S. KOPLIN					
22	V	27 EMP. BEN.- D. MAGAFAS				558	558
23	V	27 EMP. BEN.- E. CASSON					
24	V	27 EMP. BEN.- S. BOGEN					
25	V	27 EMP. BEN.- S. LEVY				674	674
26	V	27 EMP. BEN.- HOWARD ALTER					
27	V	27 EMP. BEN.- NON-OWNER					
28	V	27 EMP. BEN. - S. AARON				365	365
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 2,122	\$ * 2,122

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sherry Mauer	Administrator	Administrative	25.00%	See Attached	3.33	8.32%	Salary	\$ 17,957	17-1	1
2	Marshall Mauer	Relative	Administrative		See Attached	1.33	3.32%	Alloc Dynamic	12,073	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 30,030		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	441,841	13	\$ 9,671	\$ 14,339	\$ 314	1	
2	6	REPAIRS & MAINT.	PATIENT DAYS	441,841	13	29,639	3,380	14,339	962	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	441,841	13	778		14,339	25	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	441,841	13	19,651		14,339	638	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	441,841	13	6,566		14,339	213	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	441,841	13	385,463	300,175	14,339	12,509	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	441,841	13	2,576		14,339	84	7
8	26	INSURANCE	PATIENT DAYS	441,841	13	31,835		14,339	1,033	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	441,841	13	66,254		14,339	2,150	9
10	30	DEPRECIATION	PATIENT DAYS	441,841	13	43,634		14,339	1,416	10
11	32	INTEREST	PATIENT DAYS	441,841	13	38,384		14,339	1,246	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	441,841	13	28,121		14,339	913	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	441,841	13	82,269		14,339	2,670	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 744,841	\$ 303,555		\$ 24,173	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning:

01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	10	59,032	59,032		1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,744	32,744		2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	12	363,103	363,103	1	12,073
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	10	487,988	487,988		4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	193,312	193,312		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	153,497	153,497		6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	8	71,542	71,542		7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	87,437	87,437	2	4,022
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	31,246	31,246		9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	2	54,060	54,060		10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	12	140,632	140,632	1	4,669
12	17	ADMIN. CMP. - HOWARD ALTI	WGHTD. AVG. HOURS	40	1	12,000	12,000		12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	12	157,563	157,563		13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	12	58,502	58,502	1	1,945
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,902,658	\$ 1,902,658		\$ 22,709

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS 40	10	5,020				1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS 40	1	3,128				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS 40	12	15,782		1	525	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS 40	10	18,288				4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS 45	6	28,556				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS 37	2	25,672				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS 40	8	22,644				7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS 45	9	12,125		2	558	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS 38	1	3,418				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS 45	2	5,010				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS 45	12	20,299		1	674	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS 40	1	1,296				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS 45	12	23,491				13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS 40	12	10,982		1	365	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 195,711	\$		\$ 2,122	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

PARK RIDGE CARE CENTER

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lease Acceptance Corp.		X	Business Lease	\$395.00	06/25/00	\$ 21,434	\$	05/25/02	5.10%	\$ 662	1								
2	Harris Trust & Savings		X	Mortgage				1,220,678			88,867	2								
3												3								
4												4								
5												5								
Working Capital																				
6	S/T NP							4,288				6								
7	Security System							6,461				7								
8												8								
9	TOTAL Facility Related				\$395.00		\$ 21,434	\$ 1,231,427			\$ 89,529	9								
B. Non-Facility Related*																				
10	See Supplemental Schedule										1,246	10								
11	Interest Income										(662)	11								
12	Interest Income (Bldg. Co.)										(384)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 200	14								
15	TOTALS (line 9+line14)						\$ 21,434	\$ 1,231,427			\$ 89,729	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number

PARK RIDGE CARE CENTER

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10	11											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
1	Allocation from Dynamic									\$ 1,246	1										
2											2										
3											3										
4											4										
5											5										
6											6										
7											7										
8											8										
9											9										
10											10										
11											11										
12											12										
13											13										
14											14										
15											15										
16											16										
17											17										
18											18										
19											19										
20											20										
21										\$ 1,246	21										

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK RIDGE CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039255

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning:

01/01/02 Ending:

12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,300 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 3,441 2. Number of Years Over Which it is Being Amortized: 5 Years
3. Current Period Amortization: 688 4. Dates Incurred: 12/93

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>			\$ <u>49,000</u>	1
2					2
3	TOTALS			\$ 49,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1994		8,310		20	416	416	2,628	9
10	Various		1995		33,691		20	1,685	1,685	9,751	10
11	Various		1997		21,547		20	1,077	1,077	5,140	11
12	Various		1998		18,893		20	946	946	4,006	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$ -	\$	\$ -	37	
38					-		-	38	
39					-		-	39	
40					-		-	40	
41					-		-	41	
42					-		-	42	
43					-		-	43	
44					-		-	44	
45					-		-	45	
46					-		-	46	
47					-		-	47	
48					-		-	48	
49					-		-	49	
50					-		-	50	
51					-		-	51	
52					-		-	52	
53					-		-	53	
54					-		-	54	
55					-		-	55	
56					-		-	56	
57					-		-	57	
58					-		-	58	
59					-		-	59	
60					-		-	60	
61					-		-	61	
62					-		-	62	
63					-		-	63	
64					-		-	64	
65					-		-	65	
66					-		-	66	
67					-		-	67	
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,337,396		34,292		42	310,562	68
69	Financial Statement Depreciation				5,180		(5,180)		69
70	TOTAL (lines 4 thru 69)		\$ 1,419,837		\$ 39,472		\$ (1,014)	\$ 332,087	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/02

Ending:

12/31/02**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,419,837	\$ 39,472		\$ 38,458	\$ (1,014)	\$ 332,087	1
2	AIR CLEANER	1999	2,791		20	140	140	502	2
3	HTG & A/C UNIT	1999	830		20	42	42	151	3
4	AIR CLEANER	1999	1,494		20	75	75	263	4
5	HTG & A/C UNITS	1999	2,412		20	121	121	393	5
6	CONDENSER	2000	9,420		20	471	471	1,217	6
7	AIR CONDITIONER	2000	757		20	38	38	98	7
8	WINDOWS	2000	3,970		20	199	199	498	8
9	WINDOWS	2000	9,433		20	472	472	1,219	9
10	GENERATOR	2000	10,714		20	536	536	1,295	10
11	GENERATOR INSTALL	2000	7,942		20	397	397	959	11
12	GENERATOR	2000	1,653		20	42	42	100	12
13	PORTABLE GENERATOR	2000	2,625		20	131	131	317	13
14	REAR ENTRANCE RAMP	2000	2,350		20	118	118	275	14
15	RAMP RAILINGS	2000	650		20	33	33	74	15
16	SECURITY SYSTEM	2000	21,434		20	1,072	1,072	2,769	16
17	COMPRESSOR	2001	1,100		20	110	110	202	17
18	FENCE	2001	1,900		20	190	190	222	18
19	BOILER REPAIR	2001	625		20	31	31	57	19
20	PLUMBING	2001	1,625		20	81	81	101	20
21	FIRE DAMPERS	2002	2,500		20	73	73	73	21
22	CARPETING	2002	950		20	45	45	45	22
23	BLINDS	2002	988		20	8	8	8	23
24	CIRCUIT BOARD	2002	964		20	48	48	48	24
25	DUCT WORK	2002	1,200		20	60	60	60	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,164	\$ 39,472		\$ 42,991	\$ 3,519	\$ 343,033	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1993		\$ 1,323,000	\$ 33,923	35	\$ 33,923	\$	\$ 306,723
5			1993	14,396	369	35	411	42	3,839
6									
7									
8									
Improvement Type**									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,337,396	\$ 34,292		\$ 34,334	\$ 42	\$ 310,562	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 63,730	\$ 9,019	\$ 5,933	\$ (3,086)	10	\$ 39,277	71
72	Current Year Purchases	4,391		334	334	10	334	72
73	Fully Depreciated Assets	106,265				10	106,265	73
74								74
75	TOTALS	\$ 174,386	\$ 9,019	\$ 6,267	\$ (2,752)		\$ 145,876	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		ALLOCATION - DYNAMIC		\$ 1,827	\$ 515	\$ 609	\$ 94	5	\$ 1,268	76
77										77
78										78
79										79
80	TOTALS			\$ 1,827	\$ 515	\$ 609	\$ 94		\$ 1,268	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,735,377	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,006	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 49,867	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 861	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 490,177	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,394 Description: \$1800 Oxygen Concentrators; \$195 Oxygen Tank; \$2399 Copier

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2000 Chrysler LHS	\$ 509.00	\$ 3,053	17
18	Allocation from Dynamic			2,670	18
19					19
20					20
21	TOTAL		\$ 509.00	\$ 5,723	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	7,144	\$		\$	7,144	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				1,705				1,705	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				14,138				14,138	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					16,315			16,315	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify): See Supplemental							3,763			3,763	13
14	TOTAL			\$		\$	22,987	\$	20,078	\$	43,065	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**Report Period Beginning: **01/01/02**

Ending:

12/31/02**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/02**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 115,376	\$ 138,923	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	357,012	357,012	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,220	10,220	6
7	Other Prepaid Expenses	1,971	1,971	7
8	Accounts Receivable (owners or related parties)	2,611	323,358	8
9	Other(specify): <u>See Supplemental Schedule</u>	72,220	73,248	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 559,410	\$ 904,732	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		49,000	13
14	Buildings, at Historical Cost		1,323,000	14
15	Leasehold Improvements, at Historical Cost	159,726	159,726	15
16	Equipment, at Historical Cost	75,709	75,709	16
17	Accumulated Depreciation (book methods)	(113,816)	(518,539)	17
18	Deferred Charges		98,000	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	825	825	22
23	Other(specify): <u>See Supplemental Schedule</u>		3,441	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 122,444	\$ 1,191,162	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 681,854	\$ 2,095,894	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,585	\$ 124,085	26
27	Officer's Accounts Payable	48,094	48,094	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,749	10,749	29
30	Accrued Salaries Payable	82,448	82,448	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,098	3,098	31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,000	89,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	65,000	43,318	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 349,974	\$ 400,792	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,220,678	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,220,678	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 349,974	\$ 1,621,470	46
47	TOTAL EQUITY(page 18, line 24)	\$ 331,880	\$ 474,424	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 681,854	\$ 2,095,894	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 424,536	1
2	Restatements (describe):		2
3	Depreciation	(21,924)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 402,612	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(70,732)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (70,732)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 331,880	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,869,417	1
2	Discounts and Allowances for all Levels	(74,640)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,794,777	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	59,451	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 59,451	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,505	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	14,646	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 38,151	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,200	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,200	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	328	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 328	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,893,907	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	457,208	31
32	Health Care	750,758	32
33	General Administration	400,951	33
B. Capital Expense			
34	Ownership	287,472	34
C. Ancillary Expense			
35	Special Cost Centers	43,065	35
36	Provider Participation Fee	25,185	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,964,639	40
41	Income before Income Taxes (line 30 minus line 40)**	(70,732)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (70,732)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,121	2,273	\$ 65,649	\$ 28.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,946	7,609	189,979	24.97	3
4	Licensed Practical Nurses	411	419	9,446	22.54	4
5	Nurse Aides & Orderlies	28,843	31,644	387,599	12.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	202	202	3,390	16.78	11
12	Dietician					12
13	Food Service Supervisor	2,369	2,579	41,900	16.25	13
14	Head Cook	2,710	2,980	39,299	13.19	14
15	Cook Helpers/Assistants	5,002	5,182	56,948	10.99	15
16	Dishwashers					16
17	Maintenance Workers	2,016	2,152	38,885	18.07	17
18	Housekeepers	8,658	9,186	95,993	10.45	18
19	Laundry	2,209	2,473	25,007	10.11	19
20	Administrator	2,176	2,403	71,427	29.72	20
21	Assistant Administrator					21
22	Other Administrative	318	318	17,957	56.47	22
23	Office Manager					23
24	Clerical	885	1,471	26,485	18.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,198	2,054	26,473	12.89	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	67,064	72,945	\$ 1,096,437 *	\$ 15.03	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 2,534	01-03	35
36	Medical Director	Monthly 7,375	09-03	36
37	Medical Records Consultant	47	10-03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,140	10-03	39
40	Physical Therapy Consultant	Monthly 92	10a-03	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	Monthly 188	10a-03	43
44	Activity Consultant	24	11-03	44
45	Social Service Consultant	22	12-03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	93 \$ 15,153		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	139 \$ 9,043	10-03	50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	139 \$ 9,043		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Annabel Leonida (1/1-5/12/02)	Administrator	None	\$ 26,510	Workers' Compensation Insurance	\$ 31,188	IDPH License Fee	\$	
Bob Weisz (5/6-12/31/02)	Administrator	None	44,917	Unemployment Compensation Insurance	7,150	Advertising: Employee Recruitment	571	
Sherry Mauer	Administrative	25	17,957	FICA Taxes	81,838	Health Care Worker Background Check	36	
				Employee Health Insurance	20,650	(Indicate # of checks performed <u>3</u>)		
				Employee Meals	606	Dues & Subscriptions	2,340	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	980	
				Employee Benefits	11,059	Allocated from Dynamic	213	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 89,384					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Lanier, Muchin, Donbrow	Legal		\$ 81			\$	Out-of-State Travel	\$
Sachnoff & Weaver	Legal		524					
Elliot & Associates	Legal		4,935					
Frost, Ruttenberg & Rothblatt	Accounting		21,356				In-State Travel	
HDSI	Data Processing		2,910					
Personnel Planners	Unemployment Consultant		540					
Econocare	Purchasing Consultant		1,300					
Urban Real Estate Researchers	Real Estate Appraisal		3,000				Seminar Expense	739
Dynamic Health Care	Bookkeeping		8,850				Allocated from Dynamic	84
See Attached	Legal		4,935					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 48,431	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 823

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting & Decorating	1996	\$ 4,353	3	\$ 725	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	1997	7,147	3	2,382	1,191						
3	Painting & Decorating	1998	1,940	3	647	647	323					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 13,440		\$ 3,754	\$ 1,838	\$ 323	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number PARK RIDGE CARE CENTER# 0039255

Report Period Beginning:

01/01/02

Ending:

12/31/02**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care \$2682
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? Yes
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,066 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 25,185
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 606 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT